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AUTHOR	Brandt, Joyce; Muhl, Jane
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ABSTRACT

This evaluator training course describes the purpose, evaluator qualifications, and workshop objectives. An outline of course content is provided. A technical bulletin, "Suggestions for Evaluating Student Clinical Performance," by Douglas R. Whitney, Marcia A. Whitney, and Johanna J. Jones, addresses the following: concepts of reliability and validity, creating a good setting for clinical evaluation, guidelines for developing items for clinical evaluation instruments, training raters and observers, gathering observations, scoring and grading observations, and use of instruments. Other contents include the following: a summary of differences between criterion- and norm-referenced measures; information on writing measurable objectives; a sample table of specifications and two sample skills tests with test situation, summary sheet, and individual skill tests. (YLB)

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PROGRAM IN HEALTH OCCUPATIONS EDUCATION

College of Education, The University of Iowa
in cooperation with
Iowa Department of Education, Bureau of Career and Vocational Education

EVALUATOR TRAINING COURSE

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Developed by:
Joyce Brandt R.N., Ph.D
Jane Muhl R.N., MA, MSN

OUTLINE

I. Introduction
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Purpose

OBRA requirements, as outline by HCFA, require all nurse aides working in nursing facilities, to successfully complete a written and skill evaluation, approved by the Iowa Department of Inspections and Appeals. The persons conducting the skill evaluation must have completed a training program. This workshop is designed to prepare these evaluators.

Evaluator Qualifications

Evaluators must meet the same qualifications as teachers. They must be a registered nurse, had a minimum of two years work experience with either geriatric residents or chronically ill patients, and must have completed an approved evaluator training program.

Workshop Objectives

Upon successful completion of this workshop participants should be able to prepare nurse aide evaluators to do the following:

* Describe the procedures for conducting nurse aide evaluations and methods to share those procedures with evaluators.
* Discuss the principles associated with valid, reliable evaluations, that allow decision makers to make accurate decisions.
* Review the skills checklists associated with the approved curriculum and describe how they will be used to evaluate nurse aides.
* Demonstrate the ability to objectively observe a nurse aide during a skills competency test and make appropriate decisions regarding nurse aide performance.
* Review the criteria for successful completion and accurately assign a weight to nurse aide performance on the skill checklist.

Certificate

Upon successful completion of the workshop participants will be awarded a certificate from the Area College.

Introduction to Evaluation for Career Education Programs

Following are some general terms and information about testing that are not included in your text.

General Terms Defined

Measurement - a systematic process of gathering quantitative information to describe students' performance or behavior. This can be compared with evaluation, which assigns a value or worth for the measured behavior.

Test - Generally an instrument carefully designed for gathering specific information or measuring well-defined performances of people. Tests can be oral, performance or written, and can measure knowledge, performance and attitudes.

Evaluation - The total process of gathering the necessary information, assigning a value or worth to the information and using this information to made decisions, e.g., students' performance is acceptable, the teaching methods need changing, etc. It is concerned with effectiveness versus ineffectiveness, valuable versus invaluable, appropriate versus inappropriate. In educational programs it includes objectives, means of obtaining objectives, output or students' behaviors.

There are three terms that describe information obtained in measurement.

Formative Measurement - These are measurements (tests) to obtain diagnostic information about students' performances. The information is then used in "formulating," revising instructional objectives, content and methods. Pre-tests, quizzes are examples.

Summative Measurement - These measurements (tests) follow a systematic instructional sequence and provide information regarding how well objectives were met. The measurements are more conclusive in nature and help teachers make decisions about student readiness or effectiveness of objectives, and methods that were used in the process. Examples are unit tests, final exams, etc.

Ultimate Measurement - These measurements are the most valuable, but most difficult to obtain. They provide information about the relationship between what students are taught and its relevancy to what they must do on-the-job. An example is a follow-up study.

Measurement/testing has several functions in education. These functions require various types of measuring instruments (tests).

Achievement Tests. An integral part of the teaching-learning process that measures classroom/performance achievement. General achievement tests sample all the knowledge, skills and attitudes that are a part of a particular occupation or subject. Diagnostic achievement tests identify strengths and weaknesses in a given unit of instruction. Performance

achievement tests require the student to perform a sample of the work/skill required to meet the objectives. Achievement test items are based on program goals or objectives. The emphasis in this course is on developing and assessing teacher-made achievement tests.

General Mental Ability Tests. Tests that gather information or measure those mental abilities that are valuable in almost any type of thinking. These tests are sometimes called intelligence tests. They are designed to measure performance as well as verbal skills. General mental ability tests can be given to individuals or to groups (Lorge-Thorndike). If needed, general mental ability tests are usually purchased from a publisher and administered by student personnel.

Aptitude Tests. Tests that are concerned with measuring a specific mental ability that is important in some particular occupation. They provide information about student's current capabilities. The information can assist in predicting success in a given program.

Interest Inventories. Tests that provide information about student's level of interest in a given field. They provide information for career guidance.

Attitude Tests. These tests are similar to interest inventories. They provide information on how students like to learn, how they feel about program tasks or work in general.

Reference Points for Measurement. A teacher can use two general points of reference when considering a student's score on a test. These points are norm-referenced and criterion-referenced.

Norm-referenced measures - when the score tells where the person stands in some population of persons who have taken the test. The main objective of norm-referencing is to discriminate, e.g., separate students with regard to class achievement, so comparisons and judgements can be made based on these comparisons (see attachment).

Criterion-referenced measurements - when the score gives information that describes how well a student has met a specified standard of performance. The score describes the student's performance related to clearly defined criteria not relative to other students (see handouts).

There are two other general distinctions that need to be made about tests. These refer to standardized and standardization.

Standardized. A standardized test is one in which the procedure, apparatus and scoring so that the exact same testing procedure can be followed at all times and an any place. Every condition that affects test performance must be specified.

Standardization. The process of gathering norm data bout a test to provide a reference point for individual scores. The "norm" group selected, as well as, standardized procedures, are critical to the interpretation of scores.

SUGGESTIONS FOR EVALUATING

STUDENT CLINICAL PERFORMANCE

Douglas R. Whitney
Marcia A. Whitney
Johanna J. Jones

Technical Bulletin No. 18

Evaluation and Examination Service
The University of Iowa
Iowa City, Iowa

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SUGGESTIONS FOR EVALUATING STUDENT CLINICAL PERFORMANCE

In nearly every educational setting, instructors must evaluate student competence. Written tests that require the student to select the best answer to a question from among several alternative choices (or to prepare answers to broad questions) are used widely in higher education. The standardized format, ease of scoring, and well-researched psychometric properties of some of these evaluation techniques have contributed to their popularity. However, if the instructor is interested in observing the actual application of principles and concepts presented in the classroom, a paper and pencil test may not be the most appropriate measure of student learning. There are many settings in which performance measures, rather than written tests, will be more valid. The clinical performance of students in health education professions is one such setting. This paper will present guidelines for the development and use of three techniques which are useful in evaluating student achievement in clinical settings: (1) the rating scale, (2) the checklist, and (3) the anecdotal record.

The major purpose of this bulletin is to discuss the application of some general psychometric principles to settings in which (1) students are expected to interact as individuals with "patients" or "clients"; and (2) sound evaluations of student achievement can logically be derived, at least in part, from the observation of students in these "real-life" circumstances. We will make some specific suggestions concerning the settings in which performance evaluations appear appropriate and/or desirable, the nature of the instruments used to record observations about student performance, and the ways in which such information should and can be used effectively. Our examples will be primarily drawn from medical, dental and nursing education; the ideas are more widely applicable than our examples may suggest (e.g., counseling, social work, student teaching).

At the outset, we should describe the learning activities which comprise a "clinical" setting. First, it is essential that each student whose achievement is to be evaluated is engaged in one-to-one interaction with a patient or client requiring the student to integrate prior knowledge in order to respond appropriately to the patient or to complete some specific task. The setting, as described above, clearly eliminates such efficient evaluation procedures as group (or simultaneous) assessment of all students by the instructor. Since group tests present all students with identical tasks and standardize most essential conditions of the evaluation, many of the suggestions which follow are attempts to instill some measure of standardization in the clinical evaluation process. The other common feature of clinical settings is that certain psychomotor and/or affective (attitude, values, etc.) learning outcomes must be evaluated simultaneously with the student's cognitive (thinking) processes. Since it is difficult to construct written examinations for such outcomes, it will be more expedient to watch the student perform the relevant activities in the clinic or in a simulated clinic setting, and evaluate that performance.

Unfortunately, thoroughly developed and tested methods will probably not become available for wide-spread use in clinical evaluation (as has happened in certain content areas evaluated by standardized written tests). Rather, it seems likely that each course or learning experience will require a unique instrument and set of administrative procedures. Fortunately, it is not difficult to conduct sound clinical evaluations, nor does it usually require any particular expertise in statistical methods or psychometric theory. This paper is intended to provide assistance for persons engaged in developing such instruments and procedures.

TWO IMPORTANT CONCEPTS: RELIABILITY AND VALIDITY

So that the reader will understand the rationale for the suggestions in this bulletin and so that solutions to problems not discussed here can be developed, it seems useful to begin with two important concepts from the field of educational measurement: reliability and validity.

The first of these, RELIABILITY, refers to the consistency with which a particular evaluation method measures whatever it measures. A reliable procedure is one in which the results represent stable or trustworthy assessments of something. For written tests, the reliability of the test score(s) is usually estimated by comparing the scores earned by a group of students on two logically equivalent sets of test questions. A set of test scores is reliable to the extent that the two scores for each student are similar. Essay examinations are graded reliably if two competent readers, acting independently, assign grades which are identical or similar for each paper. Similarly, clinical evaluations are reliable to the extent that competent judges, acting independently, would agree about the level of achievement for each student. In general, any decision made about the setting in which the students are observed or about the instrument used to record the observations which seems likely to result in better agreement among competent judges is likely to improve the reliability of the evaluations. If two or more judges are used, the reliability of the evaluations can be directly estimated and expressed as a correlation-type index. If only one set of judgments is available, the case for adequate reliability must be made on a logical basis.

VALIDITY, on the other hand, is the degree to which the evaluation procedures produce information in the INTENDED aspects of the students' achievement. As such, it is a characteristic less subject to quantification than is reliability, and the assessment of the validity of an evaluation procedure must rest heavily on a logical analysis of the procedure.

A valid instrument is one that is free from systematic bias. Every student must have a fair opportunity to perform the behaviors that are being observed. If this is not so, then the procedure is invalid. The validity of the measurement also depends on the extent to which professionals in the field agree that the behaviors being observed and evaluated are critical to successful professional practice. The behaviors should also be consistent with the instruction that the student has been exposed to before entry to the clinical setting. Careful consideration should be given to these qualifies as the clinical evaluation instrument is being developed.

CREATING A GOOD SETTING FOR CLINICAL EVALUATION

Regardless of which type of clinical evaluation instrument will be used, there are important elements of the setting which should be considered before the instrument is developed. Each of these has a major influence on the reliability and validity of the evaluations.

Who will be observing the students?

Clinical evaluation instruments require one or more observers to record information about student performance. It is important to seek an appropriate balance between the amount of time required to observe a typical performance by each student, and the amount of time the observers have available to watch that performance. For example, a long and detailed list of procedures to be accomplished by the student can not yield very reliable results if the observer is able to spend only a few minutes with each student. If the observers are faculty members with many other responsibilities (or responsibility for many students) in the clinical setting, brief forms that can be quickly completed are preferred. In such a situation, it may be necessary to have three or four persons observing different aspects of the student's performance in order to arrive at a valid composite evaluation.

It is also important to consider the nature of the contact the observer will have with the student. Observers are rarely able to simply watch the student and evaluate the performance. More typically, the observer will be involved with other duties while the student is working. This may directly affect the validity of the evaluations. For example, if a dentist works in an office area that is separate from the area where a dental auxiliary student works, the dentist may be unable to observe many aspects of the student's performance and be unable to provide valid observations. Before asking persons to complete clinical evaluations instruments, consider carefully which aspects of the student's performance they will have been able to observe. The general guideline here is that people can only validly evaluate those behaviors which they have personally and purposefully observed.

It requires some commitment on the part of observers to give reliable clinical evaluations. Observers should be asked to assist in developing the instruments and the guidelines for their use. Some additional time should be spent training observers in the use of the procedures. It will certainly require time and careful thought to observe the student and produce valid evaluations. When asking persons to function as observers, be as explicit and accurate as possible about the time commitment that will be required. Even if the requirements are made explicit, some observers may be unwilling or unable to produce valid evaluations. Clues to an uncommitted or inept observers generally can be found in a non-discriminating pattern of observations—for example, persons who turn in "line" ratings (e.g., all "3's") for nearly all behaviors and students, or those who report all characteristics positively or all negatively. These patterns often indicate inadequate consideration in evaluating student performance.

It is also important to consider the degree of expertise required on the part of the observer. It may not always be necessary to use professionals

for all evaluations. Non-professional observers can often be trained to be valid evaluators of complex procedures and even of certain aspects of the quality of student work. You should consider the possibility of using trained observers who are able to focus much of their energy on the evaluations for certain types of observations.

Where will the observations be made?

A second element to consider as you develop your instruments is the context in which they will be used. If the setting is the actual clinic, then the evaluation of student performance may be secondary to the primary goal of service. That is, students work with patients in order to help the patient, not to provide samples of their performance. Likewise, the patients who are being treated expect quality care and professional interactions with the health care specialists. In most clinic settings, this means that the student is not allowed to proceed in a faulty or dangerous manner and that the instructor (observer) will intervene to correct faulty procedures as soon as they are noted. While this intervention is certainly necessary to insure proper treatment, the final product can not be taken as an accurate sample of the student's achievement. Rather, the adequacy of treatment must be evaluated on the basis of the instructor's judgment of what the product would have been had the intervention not occurred. This pattern, while potentially instructive for the student, does not allow a direct observation of the student's independent achievement and may diminish somewhat the validity of the evaluation.

The major advantage of the clinic setting is that it is reality. The elements of this setting are frequently identical to the elements that the student will face after completing professional training. There should be maximum transfer of learning from this setting to post-graduate professional practice. The primary disadvantages stem from the inability to standardize

the patient base, since each student works with persons who come to the clinic. There may be important dimensions of a student's performance that can never be observed because of the particular sample of patients who happened to be assigned to that student. Also, because each student works with different patients, it is difficult to compare the performance of different students because there is no equivalent or standard set of problems faced by all students. Finally, during certain periods, the rate of patient contact may vary considerably so that some students may treat twice as many patients as others. This difference in "base rate" limits our ability to make evaluations of equal reliability, since some are based on very few observations.

The disadvantages of the real setting become the advantages of a simulated, or artifical setting. Here it is possible to control the stimuli that confront the student. Using a computer "patient", or a live "programmed" patient allows you to observe the student in a setting where learning and evaluation <u>are</u> the primary goals. You can arrange the setting to insure that each student confronts a similar or identical set of problems that will elicit the behaviors you want to observe. Simulated settings should also be used when student errors may be too "costly", or when it is simply not possible to make observations in the real-life setting. The artificiality of the setting, however, may make it impossible to replicate <u>every</u> element of the real setting that may affect student performance.

As a third strategy, rather than observing a student in either real or simulated settings, you can review case plans prepared by the student which outline what will be or was done with the client. This approach may be appropriate if your primary concern is with the student's ability to diagnose and prescribe treatment for the patient. A case plan will, of course, not provide a direct observation of the student's application of knowledge or interpersonal skills in the clinic setting. The advantage of the case plan

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approach, where it is appropriate, is that observers can review the plan whenever they are free. The disadvantage is that you do not view the interpersonal aspects of the student's care, nor do you witness the actual enactment phase of the plan.

What student behaviors are you interested in?

The last critical question you should answer, prior to the development of any instrument, is what specific kinds of student performance are of interest. If you are interested primarily in student knowledge, or cognitive outcomes, you may use a different set of instruments than if you are concerned with the application of that knowledge. Psychomotor skills must generally be viewed to be evaluated. On the other hand, it is almost impossible to view affect outcomes directly. For the latter, you must frequently rely on indirect methods to assess how the student feels about the clinical setting and/or patient. In some cases you may be concerned with all three kinds of outcomes.

Cognitive Outcomes. Students are usually taught principles and concepts in the classroom. You would usually use written tests to assess how well they understand these fundamentals, but may still need to evaluate the application of this learning. Perhaps you are interested in observing how well the student can diagnose or manage a typical or problem patient. Perhaps you are interested in observing how well the student can explain procedures and facts about a disease to a patient. It is often possible to observe these aspects of student performance without developing clinical evaluation instruments. (Written tests can be developed in many instances.) The use of written patient-management problems that permit students to make diagnoses, plan treatments and learn the results of their decisions is increasing. Likewise, the computerization of such problems extends even further the realism that can be provided in what is essentially a written

evaluation instrument. It is desirable to use a written form of this type whenever it is not essential that you view the actual performance because of the much greater standardization which can be accomplished. Every student experiences a standard, pre-specified set of options that simplifies problems of evaluation as well as improves the reliability of the examination. Administrative problems are also considerably reduced with written exams. Students can generally complete patient management problems on their own, when they are free—and it is not necessary to locate, train and schedule observers.

Psychomotor Outcomes. If psychomotor outcomes are important, you will usually want to arrange for the actual observation and evaluation of student performance. As noted previously, you can arrange to have the student interact with the patient in either a real or simulated setting. Whichever setting you choose, you should have at least one qualified person available to observe and evaluate the student's skills. The form you use for this purpose may be any of the three that will be discussed shortly in more detail—the rating scale, the checklist, or the anecdotal record. In addition to (or instead of) the on-site observation, you can videotape the student's performance. This will permit you to evaluate the student's actions under more leisurely circumstances, and the student to learn by watching his/her own performance.

Affective Outcomes. The affective outcomes of education are very difficult to observe and measure directly. The patient responds to the personal traits of the student as much or more, perhaps, than to the cognitive and psychomotor skills. The manner in which a patient is treated certainly affects the way in which the service at the clinic is perceived. Less directly, patients' perceptions of the service also are likely to influence their compliance with any treatment plans. The measurement of affective qualities, or personal traits of the student, presents many problems. Since there are many possible

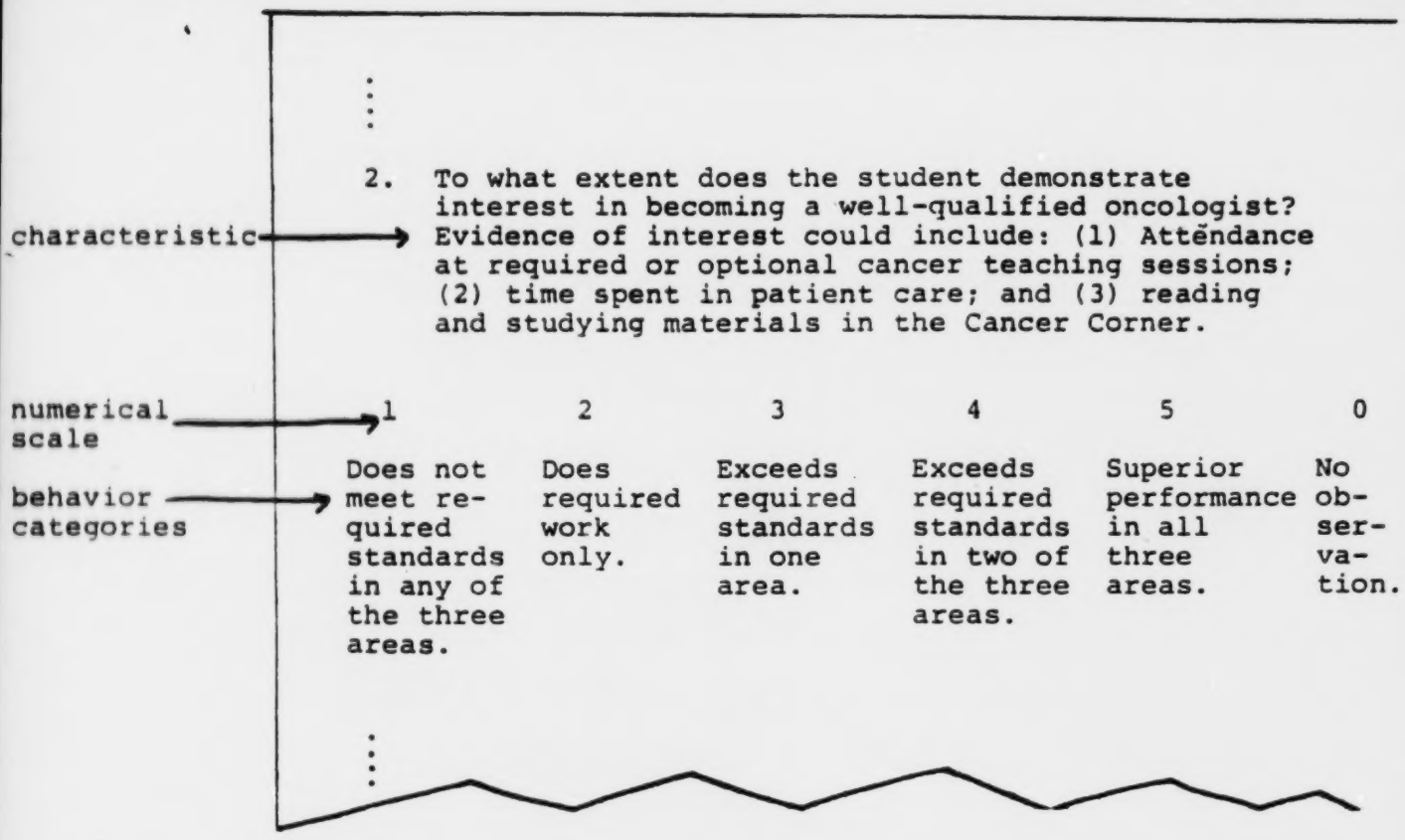
explanations for any single student behavior, you should usually observe many behaviors before trying to infer the presence or absence of a personal characteristic or affective outcome. It may require many raters in order to assure adequate reliability. This is one area, however, in which patients can often assist in the evaluation. (Patients are not usually able to provide information about what the student knows or is able to do, but they can certainly tell you how the student made them feel or what kind of an impression was made.) It is essential, of course, to establish an objective framework to reduce the possibility that patients will tell you what they think your want to hear. You will probably want to assure the patients that their responses will be anonymous and to emphasize that the student needs accurate information about performance in order to learn and improve.

As indicated at the beginning of this section, there are many factors to be considered before selecting the setting and instrument to use in evaluating student learning. From these considerations should emerge a very clear idea of the kind of instruments that will be required.

GUIDELINES FOR DEVELOPING ITEMS FOR CLINICAL EVALUATION INSTRUMENTS

Three types of items are used in clinical evaluation instruments: (1) the rating scale, (2) the checklist, and (3) the anecdotal record. Each will be defined and discussed in turn.

The rating scale is a series of items asking an observer to evaluate student performance or characteristics relative to scaled behavior or numerical categories. The items on the rating scale generally cover a broad range of student characteristics, and permit the observer to make judgments about the quality or quantity of the behavior that is being observed. A sample item from a rating scale is given on the following page.


2. To what extent does the student demonstrate interest in becoming a well-qualified oncologist? Evidence of interest could include: (1) Attendance at required or optional cancer teaching sessions; (2) time spent in patient care; and (3) reading and studying materials in the Cancer Corner.
characteristic
numerical scale
behavior categories
1
2
3
4
5
0
Does not meet required standards in any of the three areas.
Does required work only.
Exceeds required standards in one area.
Exceeds required standards in two of the three areas.
Superior performance in all three areas.
No observation.

It is appropriate to use a rating scale when you want to make global evaluations about a small number of student characteristics. Such scales can be used in either a real or simulated setting or applied to case records as well.

If you are concerned primarily with the presence or absence of certain behaviors, and not the quality, then a checklist may be the most appropriate format. A checklist generally includes a series of items describing student behaviors. Checklists are used to indicate whether the observer saw the student perform the indicated action. Like the rating scale, the checklist can be used in both real and simulated settings. A sample item from a checklist is given on the following page.

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For each item listed below, check the appropriate column.

	Yes	No	Not Relevant
. . .			
10. Did the student expose the area to be examined?	____	____	____
. . .			

A checklist can be used to tally minimum competency behaviors, or frequency of behaviors. If there is a chronological sequence to the performance that will be observed, the items on the checklist should be arranged to parallel that order.

One problem affecting both rating scales and checklists is that the behaviors the observer is being asked to rate may be an inadequate sampling of the observed events. The anecdotal record, which asks the observer to describe any positive or negative incident, is less standard, but more flexible. It allows any specific focus to be used as a basis for considering possible incidents to be recorded. Instructions for a sample anecedotal record are given below.

ANECDOTAL RECORD

DIRECTIONS: You will be observing a junior medical student taking a patient's history. Please write a brief paragraph at the conclusion of your observation describing the student's performance. Comment specifically on the student's questionning ability and interaction with the patient.

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Regardless of which type of instrument you develop and use, there are some general guidelines that apply. First, and most important, the instrument needs to be used. The people who will review the evaluations must believe that the instrument and procedure is valid, and accept the outcomes as important and reliable. An instrument is more likely to be used if it represents an economical use of time and energy for the observer. Very often, the persons who will be rating student performance will have many additional responsbilities, and will simply not use a form requiring a lot of time and energy. A clearly worded form that can stand on its own without explanation is also more likely to be used. Brief and understandable forms usually require less time to train raters and are less frustrating to use.

Each clinical evaluation instrument should be prefaced with clear instructions that fully explain how the form is to be used. Any potentially ambiguous terms should be explained or illustrated. The instructions should describe clearly the setting in which the form is to be used, and the manner in which it is to be completed. There should also be an indication of how and by whom the results will be used. Clear instructions serve a dual purpose: (1) they provide a common base for all raters that may improve the reliability of the evaluations, and (2) they anticipate questions that may arise during the actual observation.

How many characteristics (or items) should appear on a rating scale? Again, there is no standard answer. It is desirable that each of the characteristics being observed be stable, be critical to successful performance, and reflect intended instructional outcomes. It may be useful to begin the development of a rating scale by asking observers to complete anecdotal records with respect to their observations of former students. The common elements that usually appear in such records suggest traits that are generally viewed as critical in either a positive and negative

sense. These traits may be used to develop rating scales or checklists. A clinical evaluation instrument should contain only important and critical characteristics, but should contain all that are relevant. There is no "magic" number of items or pages, but the instrument should be only as long as necessary. No longer. Don't ask the observer to note information that will not be used.

The more clearly the behaviors to be observed are defined, the more reliable the evaluations are likely to be. Ambiguous terms such as "competent" or "professional" are likely to have a different definition for each rater. Similarly, global evaluations such as "good" or "fair" are difficult to interpret when used by a number of raters. All raters should attend to identical characteristics (and only those) prompted by the language you have used. Additionally, you would like all raters to agree on the evaluation of those characteristics for a given student. The more precisely terms are defined, the more likely you are to achieve these outcomes. It may be necessary to arrange for meetings among competent professionals in order to agree on the behaviors that are characteristic of "professional" or "competent" persons on the categories of interest.

A frequent question with respect to rating scales is, "How many categories should there be on the scale?" Should there be 3 points on the numerical scale? Five points? Seven? Eleven? Again, there is no "best" number. There should be as many descriptive categories as there are meaningful differences—but no more. You should review rather carefully, however, any numerical scale that exceeds nine points. Are there really that many meaningful distinctions on the trait in question? Or will raters have a difficult time determining their evaluations? Such difficulty could lead to disagreement among raters. It is not necessary to have the same number of categories from item to item. If only three meaningful behavior categories emerge on one

characteristic and five can be identified with respect to another, those differences should be reflected in the number of categories on the rating scale. Forcing the same number of numerical points on each characteristic may be requiring unnecessary and unreliable distinctions.

There are also some general problems unique to the use of rating scales and checklists. Raters may not properly distinguish among the various characteristics for a given individual, but instead allow a general notion of "goodness" or "badness" to influence all ratings for a particular student. This tendency, sometimes called the "halo effect," introduces a subtle bias to the ratings and leads to a lack of validity. Some raters tend to give extreme ratings to every individual on every dimension--other raters usually mark near the center of every scale. Raters may be generous to a fault, perhaps thinking that criticism may hamper student motivation or lead to insecurity in performance. It is possible to equalize the impact of these unwelcome distortions by randomly assigning raters to students or observation segments, or to eliminate them by carefully training raters before the observation sessions. Part of that training period should be used to focus the raters' attention on each separate characteristic being observed and discuss the distinctions between characteristics as well as to clearly define each behavior category (or numerical scale point) used to record observations.

SUMMARY: Development of Instruments

Guidelines for the development of clinical evaluation instruments might be summarized as follows:

1. Use the form that is most appropriate for your purpose. Rating scales allow the observer to make qualitative distinctions, whereas checklists are used to note the

presence or absence of behaviors. If you need to allow the observer more freedom in recording observations, or if you have an incomplete understanding of the behaviors that are critical, an anecdotal record may provide the best documentation of behavior.

2. Use precise, behaviorally defined terms whenever possible. Include clear and complete instructions as a part of the clinical evaluation instrument.
3. Use only as many behavioral categories as are necessary to exhaust the meaningful differences on the characteristic being evaluated. It is not necessary to use the same number of categories for all characteristics.
4. If there is a natural order to the behaviors being observed, parallel that order on the instrument used to record the observations.
5. Ask the observer to attend only to those behaviors which are critical to successful or unsuccessful performance and reflect the intended outcomes of instruction.
6. Make the form easy to use. Be sure that the persons who will be using it agree that it is valid. Keep it brief. Make it appropriate to the setting in which it will be used and for the persons who will be using it.
7. Be alert to certain tendencies of raters that may interfere with the validity and reliability of the measures. Among these tendencies are the "halo effect," "generosity error," and extreme or middle-of-the road ratings.

TRAINING RATERS AND OBSERVERS

Raters should be clearly informed as to the extent and nature of the obligation that will be required on their part. Estimate the number of hours to be required for training, observing, rating, and providing feedback to the student or the student's instructor. Rater commitment is often enhanced if the raters are actively involved in the development of the observation forms. Raters will need training in the use of any observation forms. If there is no opportunity for face-to-face contact, you must rely completely on written directions and instructions. Under these circumstances, a brief form with the very explicit items is especially useful. Each instrument should include a statement of purpose and clear instructions as to how the observations are to be recorded. The conditions under which the observations are to occur should be clearly described, and the observer should be told how the information will be used. When you have no opportunity to personally train raters, all guidance or training must be included on the form itself. That is, generally, a rather difficult task!

Suppose that you find that you can spend one hour training the raters. How could you most profitably use that time? A good starting point might be to describe the process that was followed in developing the instruments (in case the raters were not involved). If raters have not been involved in the development you may need to persuade them that the characteristics being rated are important and that their part in the rating process is vital. You might discuss the rationale that was followed in the selection of items--why particular items were included, why others were excluded. Providing this type of background information before looking at the details of the form may prevent unnecessary and time-consuming arguments later in

the session. Much of the time during this session should be spent discussing and clarifying definitions. The more ambiguity that can be eliminated, the more reliable the ratings will be.

Should you find yourself in the enviable position of arranging a second meeting with the raters, you can use their comments from the initial set of observations as a basis to improve the forms. The experience of each rater in using the form will provide valuable information about unanticipated problems.

One strategy that seems to be effective as a part of rater training is a practice session. The stimulus could be a videotape of actual student performance or a simulated situation that all raters would be asked to observe and evaluate using the appropriate forms. The use of the forms (and attendant questions and problems) will highlight important points for discussion.

GATHERING THE OBSERVATIONS

Reliability is also enhanced by multiples--multiple raters and multiple ratings. If you can only have one or the other, it is probably preferable to have more than one rater evaluate each student in order to randomize rater tendencies that interfere with valid evaluations. If there are only a few available raters, urge them to make multiple ratings of each student at well-spaced intervals. This will reduce some of the day-to-day distortions in rating. It will not, of course, reduce the systematic biases that particular raters bring to the observation setting. Urge the raters to do their evaluation on the spot, or at least with a minimum time lag between observation and recording. If ratings can not be completed at the observation site, encourage raters to make notes on key points in order to help them complete the evaluation later. Raters should be <u>encouraged</u> to exercise the option to "not rate" if that is most appropriate. In some

instances the raters may simply have not had sufficient opportunity to observe all of the characteristics contained on the instrument. Urge the raters to record their evaluations independently of one another. After you have collected all ratings, summarize the outcomes and return the summary to the raters to be used as a basis for further discussion about student performance and about the clinical evaluation procedure itself.

SCORING AND GRADING THE OBSERVATIONS

Scoring should be guided by the use that will be made of the information resulting from observations. If the clinical evaluation form is being used chiefly as a source of information for improving student learning or faculty teaching, a score may not be necessary. A mere description or tally of the behaviors that are observed may be sufficient to revise instruction or communicate results to students.

If it is important to make decisions on an item-by-item level, as is frequently the case when some minimum performance level is necessary by the student on <u>every</u> trait being observed, scores on each item will probably be sufficient. A score that compresses all these traits into a single summary number may obscure important information. On the other hand, when a single (summative) decision about student performance must be made, as in the final evaluation of a students' learning, a total score that accurately summarizes a variety of information is necessary. If you must assign grades to students by ranking each student relative to all others in a course, a single composite number for all students will be needed. If a single score is necessary, then two factors should be considered in the weighting of evaluations on each characteristic. (1) The weight assigned to each of the characteristics being evaluated (the separate items on the rating scale or checklist), and (2) the weight to be given to each behavior category on the separate items. While it is not

important that the numer of categories be consistent from item to item, it is important that the numerical range of the rating scale be consistent in order that weights attached to each item be accurately reflected. The weighting and scoring decisions are basically numerical and psychometric in nature. A person familiar with measurement theory can assist in developing scoring techniques that will suit your needs.

More critical questions that must be addressed in order to assign weights and scores include, which traits are critical, to what degree, and how much is required for "satisfactory" achievement. These decisions are necessarily subjective, and should involve as many professionals as possible. What criteria are used? One suggestion is to try to define the minimum level of competency to which the public is entitled. Every student that graduates from your program should meet this standard as a base requirement.

Grades may be associated with the scores resulting from the use of clinical evaluation instruments in two ways. The first is a multiple cut-off method. This is preferable when there are minimum standards that are essential on a variety of traits. In this approach, minimum standards must be met on all characteristics before the student's achievement is certified as successful. The second method is based on the principles of multiple regression, where each characteristic receives some pre-specified weight. A high score in one area can offset low scores in other areas and still lead to certification. If all the competencies that are being observed are in one general domain, then the multiple regression method may be very appropriate, as the specific items may be subtle variations on the over-all domain. On the other hand, if the items cover a variety of domains, with distinct areas of importance being represented, then the multiple cut-off grading method is more appropriate.

SUMMARY: Use of Instruments

The following guidelines are offered for the effective use of clinical evaluation instruments:

1. Let the information you acquire be determined by the use you will make of it. Evaluations conducted to detect specific errors or to prescribe additional learning activities typically require more descriptive information and less numerical data. The reverse is true for evaluations conducted at the conclusion of a course or sequence of instruction.
2. Train the raters! This, perhaps more than any other single factor, will reduce problems with the instruments and increase the reliability and validity of the evaluations. Face-to-face sessions are most desirable, but in their absence you may have to rely on explicit written information and clear instructions. Raters can function most effectively if they understand and agree with the principles that guided the development of the instrument.
3. Use a scoring scheme that reflects both the importance of the traits being observed and the use that will be made of the data. If a single, summative decision about student performance must be made, then it will be necessary to derive one single composite score that accurately reflects all the information contained on the clinical evaluation instrument. If a series of multiple decisions about student performance will be made, it may not be necessary to derive one score, but would be more appropriate to score each item separately. It may not even be necessary to score

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the items at all, if your only concern is to provide the student with descriptive feedback that can be used to change behavior.

A FINAL NOTE

Conducting evaluations of clinical performance is a time-consuming process, but not a mystical one. You should, however, expect the process to be evolutionary, with many revisions required before the results will be acceptable. Once developed, clinical evaluation instruments and procedures can provide a valid and reliable source of information about student performance that cannot be obtained in any other manner. It is hoped that the suggestions offered in this paper will provide some assistance to you in the process of developing clinical evaluation instruments. All you have to do is to apply them in your particular setting!

Differences Between Criterion-Reference and Norm-Referenced Measures

Here is a brief summary of some of the differences between criterion-referenced and norm-referenced measures. The differences are, in most cases, a matter of degrees.

	Factors	Criterion-Referenced	Norm-Referenced
1.	Purpose	To acquire information on the degree to which external performance standards (behavioral objectives) have been met	To acquire information for relative internal comparisons
		Description of maximum performance by individuals, groups and treatment (teaching) affect	Comparison of individuals, especially when a degree of selectivity is needed
2.	How scores on tests should vary	Very little	A great deal
3.	Item difficulty	Tends to be easier, with some range	Tend to center around 50% item difficulty
4.	Type of test items	Great variety - less emphasis on selection-type items	Some variety - but emphasis on selection-type items
5.	Discrimination ability of items	Not emphasized	Highly emphasized
6.	Types of validity	Content validity	Criterion-related validity
7.	Reliability emphasis	Some concern with internal consistency because of concern for domain sampling	Great concern with parallel forms and test-retest stability
8.	Problem with student guessing	Can affect results	Generally not a problem
9.	Importance of items that were missed	High	Emphasis on number missed
10.	Keeping items secure	Not of great concern	Great concern
11.	Use in education	Instruction	Guidance, selection, grading

WRITING MEASUREABLE OBJECTIVES

Objectives are classified according to three domains or categories of learning:

Cognitive - intellectual skills such as knowledge, understanding and thinking.
Affective - outcomes that emphasize feeling and emotion such as interests, attitudes, appreciation, and values.
Psychomotor - skills that emphasize neuromuscular coordination.

It should be noted that objectives often involve more than one domain, but one is usually dominant.

The affective domain, while critically important, is often omitted because of the difficulty in stating and then measuring objectives. When the educator values this aspect of training but doesn't specify it behaviorally, students can't receive the clear message, and the educator is guilty of a hidden agenda. Thus, writing objectives is really a communication process.

Taxonomy of Cognitive Objectives (Bloom, 1956)

Knowledge	- involves recall of facts, principles and terms in the forms in which they are learned.	defines, describes, identifies labels, lists, matches, names, outlines, reproduces, selects, states.
Comprehension	- involves the ability to grasp the meaning of such as restating knowledge in new terms and giving examples.	converts, defends, explains, extends, generalizes, gives examples, infers, paraphrases, predicts, rewrites, summarizes.
Application	- involves the use of theory or abstractions in concrete situations such as procedures to be applied or theories to be applied.	changes, computes, demonstrates, discovers manipulates, modifies, operates, predicts, prepares, produces, relates, shows, solves, uses.
Analysis	- involves the breaking down of knowledge or a concept into component parts according to relationships.	breaks down, diagrams, differentiates, discriminates, distinguishes, identifies, illustrates, infers, outlines, points out, relates, selects separates, subdivides.
Synthesis	- involves organizing parts or, elements so that they form new patterns, ideas, or structures.	categorizes, combines, compiles, composes, creates, devises, designs, explains, generates, modifies, organizes, plans, rearranges, reconstructs, relates, reorganizes, revises, rewrites, summarizes, tells, writes.

Evaluation	- involves a decision or judgment of the value of knowledge, materials, and methods for given purposes.	appraises, compares, concludes, contrasts, criticizes, describes, discriminates, explains, justifies, interprets, relates, summarizes, supports.

Taxonomy of Affective Objectives (Krathwohl, 1964)

Receiving	- attends to particular phenomenon or stimuli.	asks, chooses, describes, follows, gives, holds, identifies, locates, names, points to, selects, sits erect, replies uses.
Responding	- voluntarily completes responsibilities and actively participates.	answers, assists, complies, conforms, discusses, greets, helps, labels, performs, practices, presents, reads, recites, reports, selects, tells, writes.
Valuing	- shows concern for the worth or value of object, phenomenon or behavior.	completes, describes, differentiates, explains, follows, forms, initiates, invites, joins, justifies, proposes, reads, reports, selects, shares, studies, works.
Organization	- develops an internally consistent value system.	adheres, alters, arranges, combines, compares, completes, defends, explains, generalizes, identifies, integrates, modifies, orders, organizes, prepares, relates, synthesizes.
Characterization	- demonstrates actions consistent by a value with verbalized values.	acts, discriminates, displays, influences, listens, modifies, performs, practices, proposes, qualifies, questions, revises, serves, solves; uses, verifies.

TAxonomy of Psychomotor Objectives (Fitts, 1962)

Cognitive	- performs skills with errors and needs direction.
Fixation	- performs each sequence of a skill correctly, but may make errors in linking skills and needs feedback.
Autonomous	- performs skill with few or no errors, with speed and without conscious thought or need for feedback.

or (Tuckman, 1972)

Acquistion - perform skill correctly in a smooth pattern of operations.

Application - automatic use of skill while consciousness is involved with preventing problems or experimenting with modification of technique.

Integration - behavior becomes a routine part of a whole activity.

or (Simpson, 1966)

Perception - aware through sensory stimulation, cue selection, translation.

Set - readiness for a kind of action or experience mentally, physically, and emotionally.

Guided Response - perform with guidance through imitation of trial and error.

Mechanism - learned response is habitual.

Complex Overt Response - high degree of skill.

Having Difficulty?

Some skills are visible and can be stated in terms of discrete behaviors. Others, especially affective ones, are less visible and no single behavior will indicate presence of the skill. In this case an analysis process can be used to describe the expected performance. To define the objective, ask the following questions.

1. What will I take as evidence that the performance has been achieved?

2. What is the basis for differentiating between those who achieve it and those who do not?

3. What instructions would I give to tell someone how to judge whether the performance level has been met?

4. Knowing persons who have achieved the performance, what is the evidence that they have attained it?

TABLE OF SPECIFICATIONS

Behaviors / Content (think about clinical objectives)	Demonstrates transfer of classroom knowledge to practice	Plans and Organizes	Laboratory/Clinical Performance			Self Evaluates and modifies as needed	Totals
			Needs to be shown how to do activity	Accomplishes activity with minimal assistance	Accomplishes activity with no assistance		
	34						35

Table of Specification
Sample of Pretest

Behaviors / Content	Recall (Remember)	Comprehend (Understand)	Application	Totals
Knowledge of types of tests and planning for a test	8 % 4 items	8 % 4 items	4 % 2 items	20 % 10 items
Principles Writing test items (all types)	10 % 5 items	10 % 5 items	0 items	20 % 10 items
Critiquing and Writing test items		6 % 3 items	24 % 12 items	30 % 15 items
Constructing the test	4% 2 items	6 % 3 items		10 % 5 items
Analyzing the test results and effectiveness of the test	4 % 2 items	4 % 2 items	12 % 6 items	20 % 10 items
	26 %	34 %	40 %	100 % or 50 test items

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SKILLS TEST NUMBER 19

Test Situation

Mrs. Jenkins is a 72 year old lady who has Alzheimers disease. You are assigned to give her care today. You will be evaluated on the following skills while doing the care:

1. Oral Hygiene
2. Positioning in bed
3. Preparing her for a meals
4. Feeding her
5. Communication
6. Hand washing

You will demonstrate hand washing once and after that at any time you are to wash your hands you will communicate that you would wash your hands to the evaluator.

If you have any questions, regarding what is expected of you please ask the evaluator before you start the test. The evaluator will not speak to you after you have begun the evaluation.

SKILLS TEST 19 SUMMARY SHEET

Name of Candidate_____

S.S. _____

Skills Evaluated and Possible Points

Skill	Possible Points	Points Received
Handwashing.....	14 points	_____
Oral Hygiene.....	13 points	_____
Positioning.....	16 points	_____
Measuring Intake.....	05 points	_____
Feeding a Resident...	17 points	_____
Communication.....	10 points	_____
Total 75 Points		Received

To successfully complete this skill evaluation at 70% level the candidate must have received 52 total points.

Passed_____ Did not Pass_____

Signature of Evaluator_____Date_____

NURSE AIDE
Skills Test

Hand Washing Technique

Equipment needed: Soap, sink, running water, paper towels, wastebasket.

Name _____

____ 1. Assemble equipment.

____ 2. Turn faucet on with paper towel.

____ 3. Discard paper towel in waste basket.

____ 4. Wet hands completely.

____ 5. Apply soap.

____ 6. Hold hands lower than elbows.

____ 7. Work up a good lather.

____ 8. Clean your nails.

____ 9. Wash hands by using a rotating, rubbing motion for one full minute.

____ 10. Wash at least two inches above wrist.

____ 11. Rinse well.

____ 12. Dry thoroughly with paper towels.

____ 13. Turn faucet off with paper towel.

____ 14. Discard paper towel in wastebasket.

*Starred items must be done or its an automatic failure.

Total Points Obtained _____

Evaluators's Signature _____ Date _____

Skills Test

Assisting With Oral Hygiene

Equipment: Toothbrush, toothpaste, emesis basin, fresh water in a cup, face towel (optional), mouthwash, and straw. Swabs for care for unconscious resident.

Name _____

____ 1. Assemble the equipment - check label for correct name.

____ 2. Wash your hands.

____ 3. Provide privacy for the resident.

____ 4. Inform resident what you will be doing.

____ 5. Position towel to protect resident's gown, sheets, etc.; or if resident is able, assist him/her to the bathroom.

____ 6. If facility policy requires, mix a half cup of water with half cup of mouthwash.

____ 7. Have the resident rinse his/her mouth with the mouthwash.

____ 8. Instruct the resident to expectorate the mouthwash into the sink or emesis basin you have positioned under the resident's chin.

____ 9. Dampen the toothbrush and assist resident to put toothpaste on the dampened toothbrush.

____ 10. If a resident is able, have him/her brush own teeth, if he/she can't, brush teeth for him/her.

____ 11. Have the resident rinse the toothpaste out of his/her mouth using the mouthwash or fresh water.

____ 12. Make the resident comfortable.

____ 13. Clean equipment and put it away. Wash your hands.

NURSE AIDE EVALUATION
SKILLS CHECK LIST COMMUNICATIONS

Communication Checklist

Name_____

_____1. Greeted Resident by name upon entering room.

_____2. Voice friendly - smiled.

_____3. Introduced self.

_____4. Answered questions correctly that resident asked.

_____5. Explained procedure, answered questions before doing Procedures

_____6. Asked questions of resident to make sure they understood.

_____7. Provided time for resident to get ready for procedures...did not rush resident.

_____8. Made resident comfortable...checked with resident on comfort or do see if they wanted something else.

_____9. Told resident they were leaving but could be contacted with call button.

____10. Generally, made resident feel comfortable throughout the procedure.

Comments:

Score Received_____

Evaluator's Signature_____Date_____

NURSE AIDE

Skill Evaluation
Lifting and Moving a Resident in Bed

Name _____

____ 1. Ask for help if necessary.

____ 2. Wash your hands.

____ 3. Insure resident's privacy.

____ 4. Tell the resident what you will be doing.

____ 5. Position pillows as taught.

____ 6. Lock wheels on bed.

____ 7. If using two aides, position each person on opposite sides of bed.

____ 8. Stand with back straight, knees bent, turned slightly toward the head of the bed. Feet 12 inches apart.

____ 9. Put arm under the resident's nearest shoulder.

____ 10. Put other arm under resident's buttock.

____ 11. Other assistant is doing the same. The leader will then say when to move. e.g. 1-2-3 pull.

____ 12. Slide resident up by straightening your knees.

____ 13. Move resident gently to prevent pain.

____ 14. Reposition comfortably.

____ 15. Wash hands.

____ 16. Report any unusual observations to supervisor.

Instructor's Signature_____ Date _____

NURSE AIDE

Skills Evaluation

Feeding a Resident

Equipment: Washcloth for washing resident's hands, napkin, silverware, straw.

Name _____

____ 1. Tell the resident you will be helping him/her to eat.

____ 2. Wash hands.

____ 3. Offer bedpan/assist to bathroom, if able.

____ 4. Help resident wash hands. Check nails.

____ 5. Position resident comfortably at the table; or if eating in bed, with head elevated. If resident in chair, be sure robe and slippers are on.

____ 6. Remove unpleasant odors/objects.

____ 7. Check to make sure the resident has the correct diet.

____ 8. Make yourself comfortable. If you sit, you and the resident will be more relaxed.

____ 9. Position napkin to protect resident's clothing. Encourage resident to assist as much as he/she is able.

____ 10. Season food according to resident's preference.

____ 11. Fill spoon/fork only half-full. (Use the tip of the spoon not the side)

____ 12. Put the food in the side of the resident's mouth.

____ 13. Alternate liquids and solids.

____ 14. Use a straw for liquids, if possible.

____ 15. Feed resident slowly. Allow him/her to chew and swallow before giving more food.

____ 16. Assist resident in washing face and hands. Make him/her comfortable.

____ 17. Wash hands. Report anything unusual to supervisor. e.g. how much was eaten or comments concerning meal.

Skills Checklist
Measuring Intake

Name_____

Intake

____ 1. Explain to the resident that the amount of fluids he/she drinks is being recorded, and ask him/her to help if able.

____ 2. Observe all fluids the resident drinks during and between meals. This is done throughout the entire period in which you are working.

____ 3. Check the intake chart for standard amounts. Make sure the resident has consumed everything being recorded.

____ 4. Record everything consumed during the shift as it is consumed, be sure and add up the amounts after meals. These amounts should be recorded in c.c's.

____ 5. At the end of the shift, total everything consumed during the shift and mark total in the designated space on intake-output sheet. This gives an overall picture of what the resident consumed for the 8 hr. shift.

SKILLS TEST 7

Test Situation

Mrs. Robins is a 92 year old lady who has been in the nursing facility for 1 year. She is confused and unsteady on her feet. You have been assigned to give her care. You will be evaluated on the following skills while providing the care.

1. Handwashing
2. Giving a bedpan
3. Measuring output
4. Oral Hygiene
5. Restraining with a posey

You will demonstrate handwashing once and after that at any time you are to wash your hands you will communicate that you would wash your hands to the evaluator.

If you have any questions, regarding what is expected of you please ask the evaluator before you start the test. The evaluator will not speak to you after you have begun the evaluation.

SKILLS TEST 7 SUMMARY SHEET

Name of Candidate_____

S.S. _____

Skills Evaluated and Possible Points

Skill	Possible Points	Points Received
Handwashing.....	14 points	_____
Oral Hygeiene.....	13 points	_____
Asst with Bedpan.....	21 points	_____
Applying Restraints..	16 points	_____
Measuring Output	10 points	_____
Communications.....	10 points	_____
TOTAL 84 POINTS	TOTAL	_____

To successfully complete this skill evaluation at 70% level the testee must have received 59 total points.

Passed_____ Did not Pass_____

Signature of Evaluator_____Date_____

NURSE AIDE
Skills Test

Hand Washing Technique

Equipment needed: Soap, sink, running water, paper towels, wastebasket.

Name _____

____ 1. Assemble equipment.

____ 2. Turn faucet on with paper towel.

____ 3. Discard paper towel in waste basket.

____ 4. Wet hands completely.

____ 5. Apply soap.

____ 6. Hold hands lower than elbows.

____ 7. Work up a good lather.

____ 8. Clean your nails.

____ 9. Wash hands by using a rotating, rubbing motion for one full minute.

____ 10. Wash at least two inches above wrist.

____ 11. Rinse well.

____ 12. Dry thoroughly with paper towels.

____ 13. Turn faucet off with paper towel.

____ 14. Discard paper towel in wastebasket.

*Starred items must be done or its an automatic failure.

Total Points Obtained _____

Evaluators's Signature _____ Date _____

NURSE AIDE EVALUATION
SKILLS CHECK LIST COMMUNICATIONS

Communication Checklist

Name_____

_____1. Greeted Resident by name upon entering room.

_____2. Voice friendly - smiled.

_____3. Introduced self.

_____4. Answered questions correctly that resident asked.

_____5. Explained procedure, answered questions before doing Procedures

_____6. Asked questions of resident to make sure they understood.

_____7. Provided time for resident to get ready for procedures...did not rush resident.

_____8. Made resident comfortable...checked with resident on comfort or do see if they wanted something else.

_____9. Told resident they were leaving but could be contacted with call button.

____10. Generally, made resident feel comfortable throughout the procedure.

Comments:

Score Received_____

Evaluator's Signature_____Date_____

Skills Test

Assisting With Oral Hygiene

Equipment: Toothbrush, toothpaste, emesis basin, fresh water in a cup, face towel (optional), mouthwash, and straw. Swabs for care for unconscious resident.

Name _____

____ 1. Assemble the equipment - check label for correct name.

____ 2. Wash your hands.

____ 3. Provide privacy for the resident.

____ 4. Inform resident what you will be doing.

____ 5. Position towel to protect resident's gown, sheets, etc.; or if resident is able, assist him/her to the bathroom.

____ 6. If facility policy requires, mix a half cup of water with half cup of mouthwash.

____ 7. Have the resident rinse his/her mouth with the mouthwash.

____ 8. Instruct the resident to expectorate the mouthwash into the sink or emesis basin you have positioned under the resident's chin.

____ 9. Dampen the toothbrush and assist resident to put toothpaste on the dampened toothbrush.

____ 10. If a resident is able, have him/her brush own teeth, if he/she can't, brush teeth for him/her.

____ 11. Have the resident rinse the toothpaste out of his/her mouth using the mouthwash or fresh water.

____ 12. Make the resident comfortable.

____ 13. Clean equipment and put it away. Wash your hands.

NURSE AIDE EVALUATION

Skills Checklist

Measuring Output

____ 1. Explain to the resident that you will be measuring the amount of urine he/she is putting out, and explain he/she must use urinal or bedpan. A special bedpan should be used if resident is also having a bowel movement.

____ 2. Instruct the resident not to put toilet tissue in the bedpan.

____ 4. After the resident has urinated, pour urine from urinal or bedpan into the graduate for measuring urine.

____ 5. Read the amount of urine by using the graduated lines on the container.

____ 6. Observe urine for unusual appearance. Report if noted.

____ 7. Empty urinal or bedpan, rinse and return to proper place. Take the toilet tissue from wastebasket and put in stool and flush stool.

____ 8. Wash hands.

____ 9. Record the amount of the output on the intake/output sheet in c.c's.

____ 10. Total the entire amount of output at the end of the shift when you total the input, and report/record as required by your facility.

NURSE AIDE

Skills Evaluation
Assisting the Resident with A Bedpan

Equipment: Bedpan, bedpan cover, tissue, water or wet washcloth, towel.

Name _____

BEDPAN

____ 1. Assemble equipment.

____ 2. Wash hands.

____ 3. Provide privacy. Explain what you are going to do.

____ 4. If bedpan is metal, warm the bedpan by running warm water over. Dry the outside of the bed pan.

____ 5. Lower siderails, fold back the top sheets if they are in the way.

____ 6. Raise the resident's gown.

____ 7. Ask the resident to bend his/her knees; put feel flat on the mattress; and raise hips by pressing feet down on the bed. If necessary, help the resident raise his/her buttocks by slipping your hand under the lower part of the back. Place the bedpan in position under the buttocks.

____ 8. If resident unable to lift buttocks; then turn resident to his/her side away from you. Position bedpan over buttock. Turn resident onto his/her toward you, bedpan will be in correct position.

____ 9. Replace covers over resident.

____ 10. Raise the backrest and knees,(if allowed). Resident should be in as much of a sitting position as possible.

____ 11. Place toilet tissue and signal cord where resident can easily reach them. Ask resident to signal when finished.

____ 12. Place side rails in up position.

____ 13. Wash hands and leave room to give resident privacy. Watch for the signal light.

____ 14. After a short time or when resident signals, return to room. Help the resident to raise hips and remove bedpan.

____ 15. Cover the bedpan immediately.

Turn Page

____ 16. If resident unable to clean self, help him/her by turning resident on side and clean with toilet tissue or damp cloth.

____ 17. Take bedpan to resident's bathroom. If resident is on intake, measure urine. Check feces, urine for unusual appearance.

____ 18. Empty the bedpan and follow the facility's procedure for cleaning the bedpan.

____ 19. Return bedpan to bedside stand.

____ 20. Help resident wash his/her hands, and position comfortably.

____ 21. Wash hands. Report any unusual observations to the supervisor.

Skills Evaluation
Safely Applying Restraints

Equipment: Restraints that have been approved by nurse, pads as required.

Name _____

____ 1. Check with nurse regarding order and type of restraint to be applied.

____ 2. Assemble equipment.

____ 3. Wash hands.

____ 4. Determine if help is needed in applying restraints; if it is, get help.

____ 5. If appropriate take the resident to the bathroom before applying.

____ 6. Calmly explain to the resident what you are going to do.

____ 7. Properly and comfortably position resident.

____ 8. Pad any bony prominences.

____ 9. Follow the correct procedure for the type of restraint being applied.

____ 10. Be sure restraints are secured in proper places; not to side rails but to the frame of the bed.

____ 11. Check to make sure restraints but to the frame of the bed.

____ 12. Check to make sure restraints are not too tight-check circulation.

____ 13. Leave resident as comfortable as possible.

____ 14. Wash hands.

____ 15. Record, if required by your facility.

____ 16. Check restraints as often as required and remove as required.